Provider Roster

Printed Name of Provider Director

446-13 (Rev. 11/2003)

Producer Licensing Bureau, Education Section

320 CAPITOL MALL SACRAMENTO, CA 95814-4309 Information (916) 492-3064

www.insurance.ca.gov Important: This form must be submitted to the Department within 30 days following the completion of the course. Late rosters may not be accepted. Pre-licensing Course: Continuing Education Course: Contact course: Non-Contact course: *(marked items not required for non-contact courses) Provider ID #: _____ Provider Name: ____ Course ID #: _____ Credit Hours: ____ Course Name: ____ *Course Start Date: ______ *Beginning Time: _____ *End Time: _____ Completion Date: _____ Military time (i.e. 1300 = 1:00 P.M.) *Class location: Street Address Suite/Room City State Zip Code The Department requests disclosure of a student's social security number pursuant to Insurance Code Sections 1749, 1749.2, 1749.3, 1749.4, 1749.5, 1749.7, and California Code of Regulations, Title 10, Chapter 5, Section 2188.6(b)(1). This information is requested so that the Department can properly identify and assign credit to students who have completed prelicensing or continuing education courses. While a student's disclosure of his or her social security number here is not mandatory, any failure to provide this information may delay or otherwise impede the Department in assigning credit for the completion of such courses to the appropriate students. ALL ENTRIES MUST BE TYPED. # Social Security Number Licensee Name: Last, First M.I. Individual License # 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. Please use backside for additional names. Certification I have reviewed this Provider Roster and the associated Course Attendance Records or examination information and certify to the best of my knowledge that the individuals listed here meet the requirements for credit. Original signature of Provider Director Date

All entries must be typed.

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